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RUN DATE: 10/22/2007				IPRS CHECKWRITE SUMMARY REPORT				
				CHECKWRITE DATE: 10/23/2007				
				FINANCIAL PAYER: NCDMH				
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	CLAIMS	CLAIMS
3404901	SMOKY MOUNTAINM H/DD/SAS	8535	1	SERVICE FACILITY LOCATION WAS NOT SUBMITTED ON THIS CLAIM. PLEASE RESUBMIT THE CLAIM WITH				
		0	0		0	1	1	0
3404904	WESTERN HIGHLAN DS LME	143	37	CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE				
		8800	28	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	0	193	3644	3451
		21	26	DUPLICATE OF CLAIM-SYSTEM				
3404910	PATHWAYS	8599	38	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		5308	34	PRIOR AUTHORIZED UNITS EXCEEDE D	0	170	3979	3809
		11	33	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404912	CATAWBA COUNTYM ENTAL HEALT	8599	270	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		24	13	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI	0	305	4217	3912
		3746	11	RELATED CODES NOT ALLOWED SAME DATE OF SERVICE.				
3404913	MECKLENBURG COM ENTAL HEALT	8505	7744	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8800	925	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	0	8893	9074	181
		79	76	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
3404916	CROSSROADS BEHA VIORAL HEAL	8505	254	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8800	95	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	0	509	2942	2433
		24	90	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI				
3404917	CENTERPOINT HUM AN SERVICES	8534	265	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F				
		11	194	CLIENT NOT ELIGIBLE ON SERVICE DATE	1	730	2832	2102
		24	72	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404919	GUILFORD CO MEN TAL HEALTHC	8505	566	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		11	73	CLIENT NOT ELIGIBLE ON SERVICE DATE	0	691	706	15
		8800	30	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
3404920	ALAMANCE CASWEL L AREA MH D	8526	2529	CLAIM DENIED, UNITS BILLED MUS T BE GREATER THAN ZERO				
		24	41	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI	0	2606	2607	1
		11	25	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404921	ORANGE PERSON C HATHAM AREA	120	57	CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				
		11	56	CLIENT NOT ELIGIBLE ON SERVICE DATE	1	341	4886	4545
		8535	56	SERVICE FACILITY LOCATION WAS NOT SUBMITTED ON THIS CLAIM. PLEASE RESUBMIT THE CLAIM WITH				
3404922	THE DURHAM CENT ER	21	1092	DUPLICATE OF CLAIM-SYSTEM				
		8800	451	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	41	1677	7010	5333
		8935	41	ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
3404923	FIVE COUNTY MH	8505	1363	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		11	65	CLIENT NOT ELIGIBLE ON SERVICE DATE	0	1577	1754	177
		8800	46	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
3404925	SANDHILLS CENTE R FOR MH/DD	8505	3923	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8800	313	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	18	4628	4767	139
		8599	148	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404926	SOUTHEASTERN RE G MENTAL HL	23	71	SERVICE REQUIRES PRIOR APPROVA L				
		11	60	CLIENT NOT ELIGIBLE ON SERVICE DATE	0	369	5659	5290
		8537	52	PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404927	CUMBERLAND CO M HC	11	222	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		21	106	DUPLICATE OF CLAIM-SYSTEM	0	432	1771	1339
		8599	35	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404930	JOHNSTON COUNTY MNTL HLTHC	11	26	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		191	1	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0	28	34	6
		8599	1	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404931	WAKE CO HUM SVC BILLING OF	21	858	DUPLICATE OF CLAIM-SYSTEM				
		8599	397	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	97	1833	11332	9499
		8621	102	60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.				
3404933	SOUTHEASTERN CT R FOR MH/DD	79	1159	THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
		8599	234	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	1738	3247	1509
		8537	153	PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN				
3404934	ONSLow CARTERET BEHAV HEAL	8505	224	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
		8599	129	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	745	1692	947
		8535	98	SERVICE FACILITY LOCATION WAS NOT SUBMITTED ON THIS CLAIM. PLEASE RESUBMIT THE CLAIM WITH				
3404935	WAYNE CO MENTAL HEALTH CTR	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404936	THE BEACON CENT ER	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404937	THE BEACON CENT ER	8535	15	SERVICE FACILITY LOCATION WAS NOT SUBMITTED ON THIS CLAIM. PLEASE RESUBMIT THE CLAIM WITH				
		24	2	PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI	0	18	1506	1488
		3411	1	PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D				

PROVIDER		HIGH DENIAL	NUMBER OF			TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	CLAIMS
3404939	EAST CAROLINA B	8505	1037	CLAIM DENIED DUE TO INSUFFICIE			CLAIMS
	EHAVIORAL H			NT BUDGET			PAID
		8534	67	SERVICE FACILITY LOCATION IS N	0	1286	3271
				OT A VALID IPRS ATTENDING			1985
				PROVIDER. PLEASE VERIFY THE F			
		11	53	CLIENT NOT ELIGIBLE ON SERVICE			
				DATE			
3404941	EAST CAROLINA B	0	0	*** NO DATA TO REPORT ***			
	EHAVIORAL H						
		0	0		0	0	0
3404942	EAST CAROLINA B	0	0	*** NO DATA TO REPORT ***			
	EHAVIORAL H						
		0	0		0	0	0
3404943	ALBEMARLE MENTA	11	46	CLIENT NOT ELIGIBLE ON SERVICE			
	L HEALTH CE			DATE			
		120	20	CLIENT ID NUMBER MISSING OR IN	5	126	1758
				VALID. ENTER CID AND SUBMIT			1632
				AS A NEW CLAIM			
		191	13	CLIENT ID NUMBER DOES NOT MATC			
				H PATIENT NAME			
3404944	EASTPOINTE HUMA	24	7	PROCEDURE CODE, PROCEDURE/MODI			
	N SERVICES			FIER COMBINATION OR PROCEDURE			
				CODE/TYPE OF SERVICE COMBINATI			
		8505	5	CLAIM DENIED DUE TO INSUFFICIE	0	17	1184
				NT BUDGET			1167
		191	2	CLIENT ID NUMBER DOES NOT MATC			
				H PATIENT NAME			
3404946	FOOTHILLS AREAM	8622	88	60 RESIDENTIAL LEVEL II TREATM			
	ENTAL HEALT			ENT RECEIVED, PA IS REQUIRED			
				FOR ADDITIONAL SERVICE.			
		10	31	DIAGNOSIS OR SERVICE INVALID F	0	139	1665
				OR CLIENT AGE. VERIFY CID,			1526
				DIAGNOSIS, PROCEDURE CODE FOR			
		8599	12	DETAIL NOT COVERED BY COMBINAT			
				ION OF RECIPIENT, PROVIDER AND			
				BENEFIT PACKAGE.			